



## Bernardino County Homeless Partners

### Homeless Provider Network Registration Form



Instructions: Please submit this form via fax at (909) 252-4088, e-mail [homelessrpf@hss.sbcounty.gov](mailto:homelessrpf@hss.sbcounty.gov), or in person at the Office of Homeless Services 1950 S. Sunwest Lane, Suite 200, San Bernardino, CA 92408.

				Date:
Member Name: <input type="checkbox"/> (Mr.) <input type="checkbox"/> (Ms.)				
Mailing Address:				
City:	State:	Zip:	Phone: ( ) -	
E-mail Address:				

Organization Name (if applicable):				
Executive Director: <input type="checkbox"/> (Mr.) <input type="checkbox"/> (Ms.)				
Business Address:				
City:	State:	Zip:	Phone: ( ) -	
E-mail Address:			Fax: ( ) -	

Member Representative (Name one Voting and two Alternates)	
Voting Name:	Title:
Alternate Name:	Title:
Alternate Name:	Title:

Regional Meeting (Please identify the primary region where you are interested in serving)		
<input type="checkbox"/> West Valley	<input type="checkbox"/> Central Valley	<input type="checkbox"/> East Valley
<input type="checkbox"/> Desert and Mountain Communities	(A member may participate in more than one Region)	

Do you provide homeless services to San Bernardino County residents? If no, please provide an explanation of services and service area.	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Are you a current voting member of the San Bernardino County Interagency Council on Homelessness (ICH)?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Will you benefit from financial gain if you are appointed as a HPN Representative? If yes, please provide an explanation.	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>

Signature:

Date:

For Office Use Only: (Do Not Write Below the Line)

Approved: <input type="checkbox"/>	Denied: <input type="checkbox"/>	Log#:	Reviewer Initials:
Comments:			